



AMEDD (EMR) Summit IV

Improving Healthcare Outcomes

LTC Ron Moody, MC
Director, AMEDD AHLTA Program Office
8 November 2006
v4



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AMEDD Summit IV



PURPOSE:

1. Summarize items from the Electronic Medical Record (EMR) Summit III conducted at Madigan AMC and previous EMR Summits
2. Detail current AHLTA issues



AGENDA

- Current AHLTA Status, Deployment, and Use
- Updates from Previous Summits
- Present Challenges/Issues



Current Status





Functional Block Strategy

Block 1	Block 2	Block 3
• Encounter Documentation • Order Entry & Results Retrieval ¹ • Encounter Coding Support • Consult Tracking • Alerts and Reminders • aCPGs (FY07) • Role-based Security • Health Data Dictionary • Master Patient Index • Ad Hoc Query Ability ² 1. Block 1 provides an interface to Legacy CHCS 2. Query/reporting of clinical data to be performed by the CDM/W	• Release 1 -Spectacle Request Transmission System II • Release 2 -Dental Charting and Documentation OTE: Jan 07 Full Deployment Decision: May 2007	• Replacement³ of Ancillary Functions of Legacy CHCS • Release 1 - Pharmacy • Release 2 - Laboratory - Anatomic Pathology • Release 3 - Radiology • Release 4 - Inpatient Charting and Documentation - Occupational Health Surveillance 3. Order entry and results retrieval in both the ambulatory and inpatient environment

2004 →

→ 2007 →

→ ~~2010?~~
Vacillating strategy being corrected by new LEADERSHIP



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Present Status

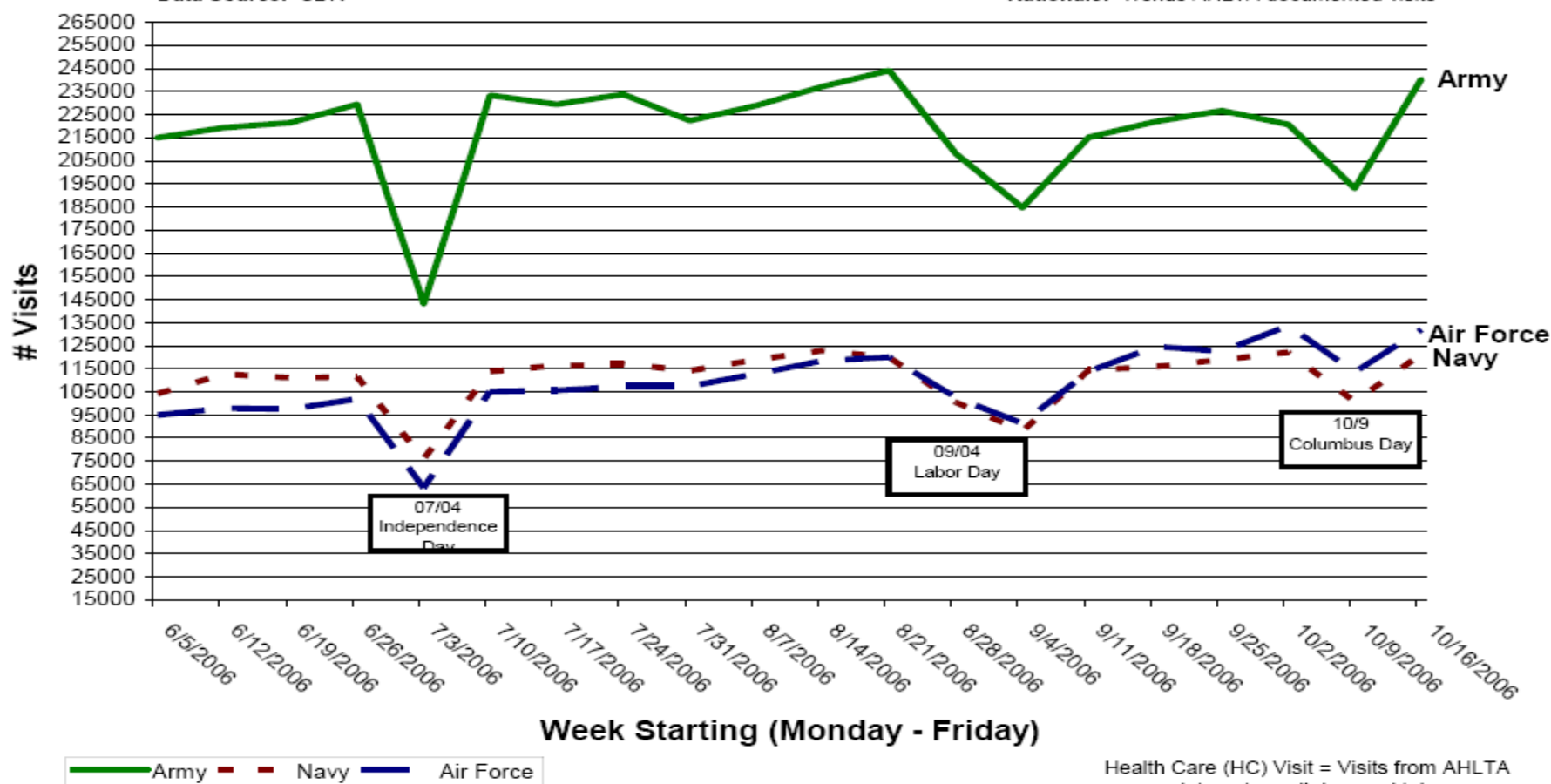


- 83% of all AMEDD Outpatient encounters
- Healthcare is highly dependent on this system

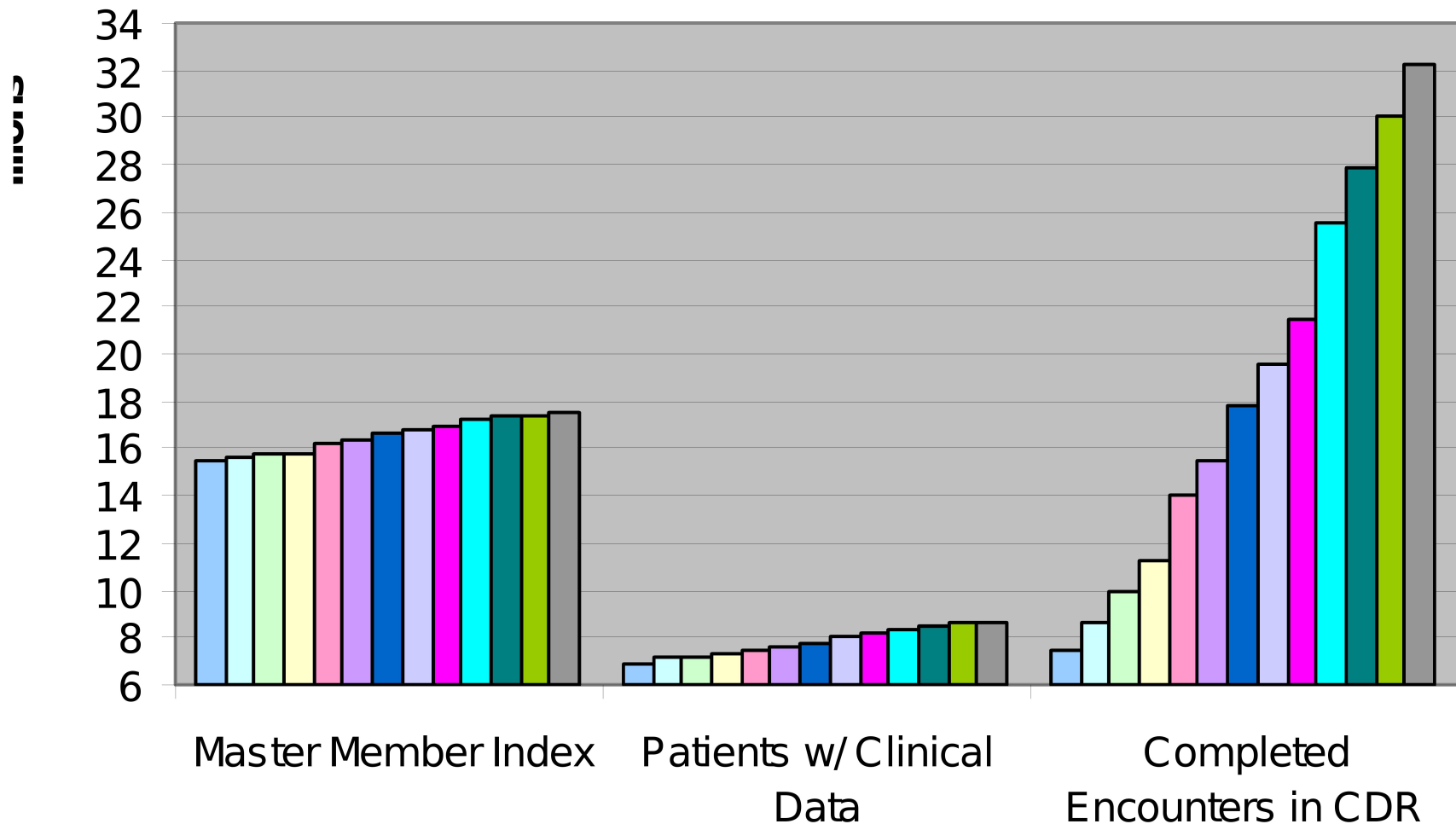
Weekly Health Care Visits Documented and Signed in AHLTA

Data Source: CDR

Rationale: Trends AHLTA documented visits



Current CDR Numbers



	8/5/2005	9/30/2005	10/31/2005	12/31/2005	1/31/2006	2/28/2006	3/31/2006	4/30/2006	5/31/2006	7/31/2006	8/31/2006	9/30/2006	10/31/2006
Master Member Index	15,477,369	15,627,954	15,734,814	15,831,468	16,271,368	16,392,631	16,605,011	16,779,158	16,923,689	17,201,878	17,333,558	17,445,646	17,571,738
Patients w/ Clinical Data	6,944,921	7,098,112	7,184,196	7,255,737	7,504,501	7,652,442	7,817,952	8,037,556	8,181,454	8,397,001	8,491,942	8,565,923	8,634,012
Completed Encounters in CDR	7,398,925	8,599,874	9,909,141	11,177,996	13,963,965	15,504,142	17,740,514	19,509,305	21,489,826	25,531,533	27,856,307	30,067,370	32,302,733

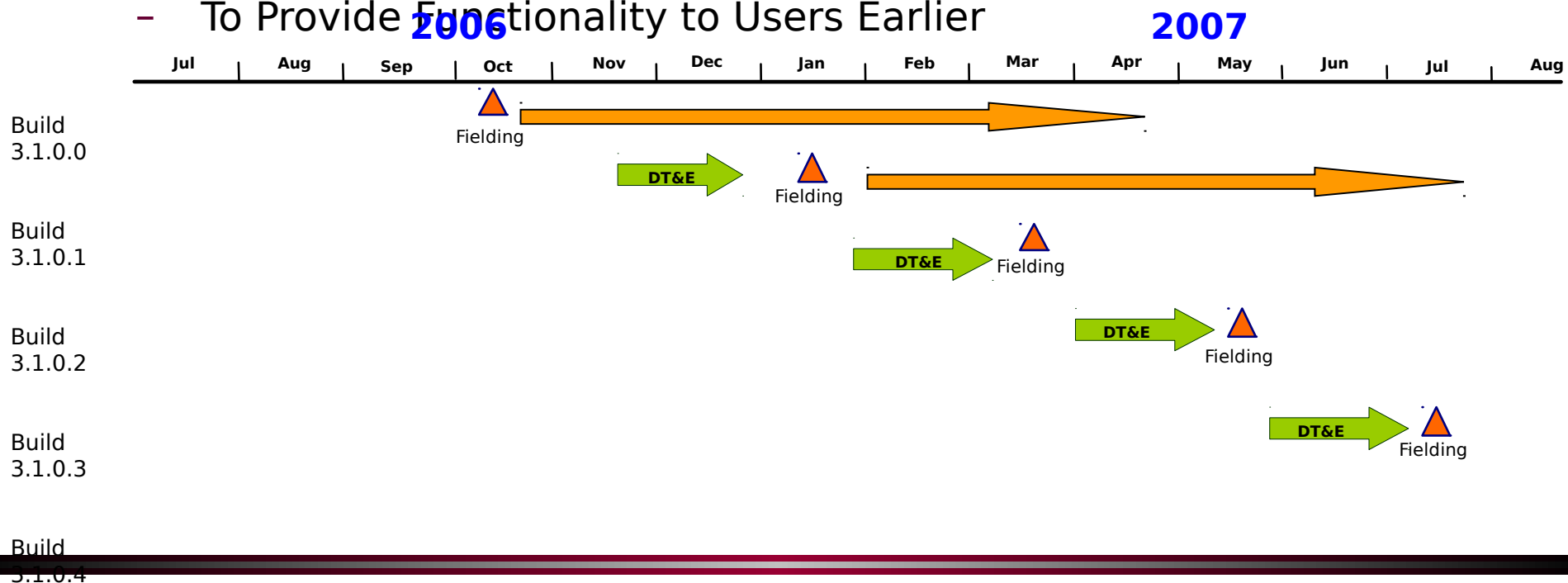




New CITPO Strategy: Getting Functionality to the Field

Recommended Strategy

- Repackage Versions: 3.1.0.2 & 3.1.0.3 (Formerly Builds 843 / 844)
- Introduce 2 New Versions: 3.1.0.1 & 3.1.0.4 (Formerly Builds 842 / 845)
- Benefits:
 - To Release Software Faster to the Field
 - To Provide Functionality to Users Earlier





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Getting Functionality to the Field (Cont.)

AHLTA 3.1.0.0 (Build 841) At limited User Testing currently, will begin release to the field in Nov 06	AHLTA 3.1.0.1 (Build 842) Release Jan 07	AHLTA 3.1.0.2 (Build 843) Release Mar 07	AHLTA 3.1.0.3 (Build 844) Release May 07	AHLTA 3.1.0.4 (Build 845) Release Jul 07
Future Appointments	.Net 3.0	841 OT&E Fixes	New Results	TSB
Telcon Redesign	Install Shield	Automated Coding AP, Meds, Allergies, Problems	Access to Sensitive Data	Multi-Site user access client
OB Summary	KEA/Reflections	Discontinued Meds	Admin Close phase 1	Document engine
Pediatric Growth Charts	Tier 3 Fixes	HIV Results	Undo Patient Check in	DFI
Post-Deployment Health Re-Assessment (PDHRA)	Performance-XML Proxy	BPR2	Unassigned provider	PRP
E&M Coding (ADM SCRs)	AHLTA NPI	Screening Module Redesign	BPR 1	SIT/OHI
Dentral Workflow Optimization	Performance-Order Entry Login	PDHRA phase 2	Integrated Immunization Module	Questionnaires Enhancements phase 1
Template Management	Tricare Reserve Select	BPR 3	ER Front End	Multi-site user access backend
	Automated Coding-Disp	aCPG	HAMTD	
	ADM P1/P2	OB Doc- aCPGs	eSF Tool	
	Alerts Overhaul		Readiness (2766)	
	Security matrix Redeisgn		ePatient Signature	
	Int Immunization Central Vaccine			
	OB Documentation-Female only section-Summary			



Summit Updates





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- **Improve feedback to users from MHS on SCRs/Trouble Tickets**

Status: CITPO established website for Trouble Ticket status. Web access to system change requests still pending. AMEDD PO: Post all AMEDD SCRs to AKO, expedite review of any item from MTF.

- **Speed delivery of critical, focused enhancements on build-independent timelines**

Status: CITPO recently announced new release strategy to expedite fielding of enhancements. Process for sustaining this has not been briefed.

- **GME: Address concerns with initial training, documentation time, and communication/education process for GME**

Status: GME-specific education material provided to GME office and consultants. Attempting to expedite GME-requested enhancement (efficient co-signing). USUHS training starting. Next target is HPSP.



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- **Improved user acceptance/use via emerging technologies**

Status: Tablet PCs are part of AMEDD EUD deployment and allow voice and handwriting recognition in AHLTA along with touchscreen. Conops and requirements submitted to HA. TATRC hosting forum on Natural Language Process and Voice Transcription.

- **Emergency Department AHLTA Use**

Status: Increase use at multiple AMEDD sites. Expanded ED Capability fielded as noted. MAMC - ? Status of getting notes into AHLTA. Dictation (Dragon Natural speak and other) has been offered. 121st leading the way.

- **Centers of Innovation (COI)**

Status: BAMC (readiness) is developing. MAMC (outcomes) prepared to start. Opportunity available to others. TMA needs to complete Service Development Policy with Service Concurrence. Funding issue remains along with non-EMR IT initiatives to be discussed.

- **Focus on Outcomes and Transformation**

Status: See other presentations. PAD officer to join AHLTA staff Nov 2006.



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- **Review Possibility to Expedite Inpatient Record Capability**
Status: Discussed under current issues.
- **Develop access to digital radiography and clinical images via AHLTA**
Status: Documents/files/images management project funded but necessary image storage presently not fully funded.
- **Clinical Data Warehouse/Mart (CDW/M) Delays**
Status: Discussed under current issues.
- **Interim System Note Transfer**
Status: SOP in place. TAMC only site that has completed. SOP also established for historic immunization transfer for non-AD.



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- **Retirement of Interim Systems (Summits I and II)**

Status: RMC retirement plans mapped interim requirements to build 841 which should be fielded beginning Jan 2007.

- **AHLTA Use at All Healthcare Locations (Summits I and II)**

Status: Deployment to CBHCOs and BAS ongoing.

- **IMR capabilities in AHLTA**

Status: Full discussion in brief.

- **Wireless and Home AHLTA Access**

Status: Wireless deployment underway. All CONUS sites scheduled for completion by FY07. Home access available using government furnished equipment (GFE) with VPN and soon by Citrix (841).



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- **Embed AHLTA Training / Education for Sustainment and New Users**

Status: Being worked by C&S, AMEDD CIO/AHLTA and MEDCOM Manpower/RM.

- **Establish the Funding and Staffing Models COIs**

Status: Not resolved.

- **Identify Method to Incorporate Existing Clinical Informatics Professionals into Career Fields that are Recognized and Nurtured**

Status: Issue not resolved. Recommend formal tasking with specific process owner.



Present Challenges/Issues





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CITPO/JMIS Strategy and Execution Remain Core Issues

- **Issue:** Vision and strategy appears centered on maintaining acquisition funds not on **outcomes**
- **Discussion:**
 - Events
 - Block 3 strategy reversals
 - Failure to mitigate known risks (LCS single point of failure, performance)
 - Allowed C2-T and AHLTA to diverge software baselines
 - Inconsistent tracking and management of projects and action
 - Developing/testing/fielding parts rather than consolidated solutions
 - Despite completing outpatient deployment
 - Continued poor QA
 - Poor coordination among JMIS program offices
 - Fireman mentality
 - Technology and EMR knowledge advancements have occurred along with major changes in political pressures
- **Recommendations:**
 - Strategy and Management must change and adapt to new facts.
 - Review the current situation and align priorities since it is imprudent to field items that will continue to jeopardize LCS stability without first correcting and prioritizing needs based upon current realities



Local Cache (Build 838): Failover Mode

- **Issues:**

- Fielded to improve accessibility but configuration dictated by funds
- Enhancements require LCS and are delayed by its performance issues

- **Discussion:**

- Oracle data base QA has been lacking as in early 2004
- Created single point of failure
- Hardware
 - Fielding not coupled with Blade Servers or back ups (promised in 2004)
 - Server configuration not optimized from lessons learned

- **Recommendations:**

- Immediate: Standardize and Improve QA on LCS
- Near term: Upgrade LCS to hot back-up to eliminate single failure point
- Prioritize: Establishing failover option to CDR if LCS fails
- Jointly field improvement solution Blade Server, Caché, and AHLTA
- *JMIS/CITPO : Provide brief and action plan for NCA and all large sites, to include capacity and processing capabilities*



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Field Funded Improvements Through Build 845

- **Issue:** New capabilities have been significantly delayed behind Local Cache deployment
- **Discussion:**
 - Large group of capabilities over two years delayed
 - New capabilities provide tools that can solve many future needs
 - Items will ease use of system and provide value
- **Recommendations:**
 - **New strategy for fielding briefed by CITPO**
 - **Must hold them to timeline**
 - **Testing (DT&E) changes are a concern**
 - **Must field image storage or document management project is useless**



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MEDCIN Upgrade

- **Issues:**

- Major complaint by providers has been MEDCIN notewriter functionality and the display of the structured note
- Complaints includes frustration with not benefiting clinically from use of structured data and inability to control note output

- **Discussion:**

- AMEDD provided SMEs for improvement of MEDCIN
- New MEDCIN version contains product features requested by users for 2 years such as control of note format, decision support, improved drawing tool, flow sheets, alerts engine, coding support
- No CITPO plan to upgrade to new MEDCIN product
 - Funding seems to be the issue
 - If not integrated will have to pay for features in less integrated fashion
- This should be a strategic decision, not a requirements debate

- **Recommendations:**

- Establish plan to advance all COTS product as part of a **Strategic Decision**
- Incorporate New MEDCIN features ASAP but no later than Build 845



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Rapid Convergence of AHLTA and CHCS II-T

- Issue: Operating two baselines increases cost, provides no added value
- Discussion – Convergence will provide:
 - Increased capabilities for both systems
 - Decreased cost of future development
 - DT&E effort and costs reduced
 - Improved synergy while retaining uniqueness
 - Unique features can be displayed depending on AHLTA “mode”
 - If “unique” feature becomes needed in other modes, it can be rapidly turned on in other modes
 - Ability to get C2T lab, rad, and medication information to CDR, not just the note.
- Status:
 - **Convergence is currently funded for FY08-09**
 - **JMIS has stated may be able to move into this year**
- **Recommendations: Expedite into this FY as a priority funded item**



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Ancillary Modules and Inpatient Pharmacy, Laboratory, Radiology, and Anatomic Pathology

- **Issue:** New portfolio and acquisition strategy proposed
- **Discussion:**
 - GE Pharmacy module ready for deployment
 - If Cerner Lab module not deployed must fund CHCS lab improvements, replace Anatomic Path, and maintain lab interoperability connections
 - Radiology module primary needs interoperability with Dynpacs
 - Inpatient CIS is over 50% deployed in AMEDD but needs better connection to CHCS order enter and document sharing with AHLTA
 - Plan is to hold formal open bid for inpatient documentation and complete suite
- **Recommendations:**
 - Concur with joint recommended joint IM and CITPO plan
 - Include in bid process complete suite to include scheduling to minimize AHLTA integration risk
 - AMEDD continue funding for Essentris for Landstuhl and EAMC
 - Consider field test of Cerner or other complete Suite of products to obtain lessons learned



System Testing and Clinical SME Input

- **Issues:**

- AHLTA and all JMIS program-office testing (with possible exception of TMIP) is being consolidated under JMIS
- Long-term intent (unification of resources and management) is logical but initial JMIS actions are not reassuring. Concerns exist regarding JMIS lead.

- **Discussion:**

- Historic CITPO AHLTA DTE has not been effective
- First test by new process with multiple undetected software defects
- New process theatrically faster because
 - Concentrates on automated testing
 - Consolidated DTE tester from all JMIS projects
- Current plan removes most clinical SME participation in testing and trouble ticket

- **Recommendations:**

- Demand that JMIS utilize clinical testers as part of testing a clinical application
- Service clinical SME support of trouble ticket review and system testing
- Closely monitor new DTE process



Individual Medical Readiness

- Issue: Readiness Items not prioritized or funded
- Discussion:
 - Suspect prioritization decisions which have resulted in inability to efficiently synch service systems and CDR immunizations
 - No funding or mapping of IMR data
 - No funding of IMR GUI enhancements agreed on by services
 - After completing outpatient deployment, IMR items are being addressed as an “Emergent” Issue requiring reprioritization of FY07 portfolio
- Recommendations:
 - Fund Immunization GUI data mapping and upgrades
 - Provide data feeds to service systems
 - Expedite CITA Synch improvement (funded)



PureEdge

- **Issues:**

- Navy does not have a PureEdge Use License (Note: AF and Army have enterprise license)
- PureEdge use is already being integrated into AHLTA

- **Discussion:**

- Forms Engine can be used to meet many future requirements and workflow needs without going to NGIT
- Generally agreed the PureEdge workflow capabilities provided valuable features

- **Recommendations:**

- JNIS/CITPO to work to resolve Navy license issue and related dependencies
- Further work on PureEdge with understanding that the tool coupled with AHLTA features through build 845 likely solves many of the issues that are funded in the FY09-13 POM under “AHLTA Clinical Specialty Capabilities”



Clinical-Business Data Utilization

- **Issues:**

- No clear plan to incorporate AHLTA data in HA-level projects
- Failure to provide data to improve clinical care at any actionable level

- **Discussion:**

- EI/DS CDM performing poorly
 - Usability and access issues due to data structure, software, and hardware
 - Containing only CDR data, weakly organized, the CDM has limited utility without purchased care data
- Funding
 - CDM provided short-term funding but long term funding not guaranteed
 - Clinical Data Warehouse unfunded in FY08-11 POM
- Other MHS data marts (M2, Pop Health Portal, MHS Insight) have do **not** have clinical/readiness data feeds from AHLTA
- AHLTA is positioned to improve POC decision support, which changes data utilization picture.

- **Recommendations:**

- Immediately provide AHLTA-unique data to Pop Health portal and others as appropriate
- **No** further funding of CDM until clear tactical and strategic plan in place
- Senior leadership direction for a unified plan to provide a Clinical-Business data solution to all levels of users



AHLTA and MEDPROS Coordination

- **Issues:**

- MEDPROS and AHLTA integration is not optimal
- Readiness regulations not coordinated with systems

- **Discussion:**

- AHLTA should capture all clinical data and medical readiness
- MEDPROS needs to be able to receive and display/report data
- Funding and prioritization must be synchronized
- Near term items below
 - Readiness and Deployment Data Sharing
 - Profile/PUHLES data to MODS/MEDPROS from AHLTA profile module. MODS for reporting to line.
 - Patient Status: Admission and quarters
 - Map Deployment Screening and Readiness Screening items in AHLTA to AKO readiness indicators/flags

- **Recommendations:**

- Establish and coordinate improvement prioritization
- Establish funding and schedule
- Coordinate with MEDPROS program office to enforce needed deliveries from MEDPROS vendor



Structured Use and Coding/RVUs

- **Issues:**

- Structured text (data) is key feature of an EMR
- Free text is necessary in any EMR for adequate communication

- **Discussion:**

- No established standard or best practice
- Structured text use is a measure of how AHLTA is used, not quality of use
- Documentation should reflect actions performed
- Presently working to associate AHLTA use (behavior) with outcomes to establish best practices
- Current information shows little correlation across MTFs.

- **Recommendations:**

- Complete contract to obtain current Central Coding Audit (PASBA)
- Publish data to comments showing AHLTA use, RVU encounter, MEDCIN use, and Coding Accuracy (CMS)
- Develop teaching - "Best Practices," and AHLTA enhancements based upon data

- **Current Items:**

- Automated coding enhancements
- Increase size of free text boxes
- Use enhancements to speed use
- Team documentation/responsibility
- MEDCIN upgrade requested as discussed
- TabletPCs



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Healthcare Team Documentation and Transforming the System

- **Issues:**

- Block 1 Deployment Completed
- Unrealized benefit from deployment

- **Discussion:**

- AHLTA use burden largely on providers
- Limited team documentation (partly due to training and system issues)
- Little workforce transformation despite major change in work
- Increasing ability to perform central monitoring to relieve MTF staff of administrative work

- **Recommendations:**

- Begin use of Team Documentation (PDF: How to Improve Outcomes with AHLTA Build 838)
- Review and reallocate staff resources to place more staff into direct clinical care
- Develop and share “Best Practices” for team use and staffing
- Consider metric that is RVU per staff cost instead of RVU per provider



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AMEDD AHLTA Program Office 100 meter targets

GOALS:

- Expand AHLTA use – Education and Process are Critical Items
 - Educational Materials
 - Trainer Conferences
 - Web Conferences for MTF users
- Deployment of SRTS 2 and Dental
- Inpatient execution (when plan established)
- MEDPROS collaboration
- Use of reminders and CPGs
- Consolidate specific best practice recommendations for GME, SRP, consult policy, JCAHO, patient registration to prevent Merge issues
- Areas requiring integration and enhancements:
 - MEPCOM
 - National Guard Profile
 - Capture of Other Health Insurance in AHLTA with TPOC transfer
 - Deployment Data Transfer: CDR <> MedPros <> AMSA



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Leading the Way Across the Chasm

Present
Care



Possible
Care

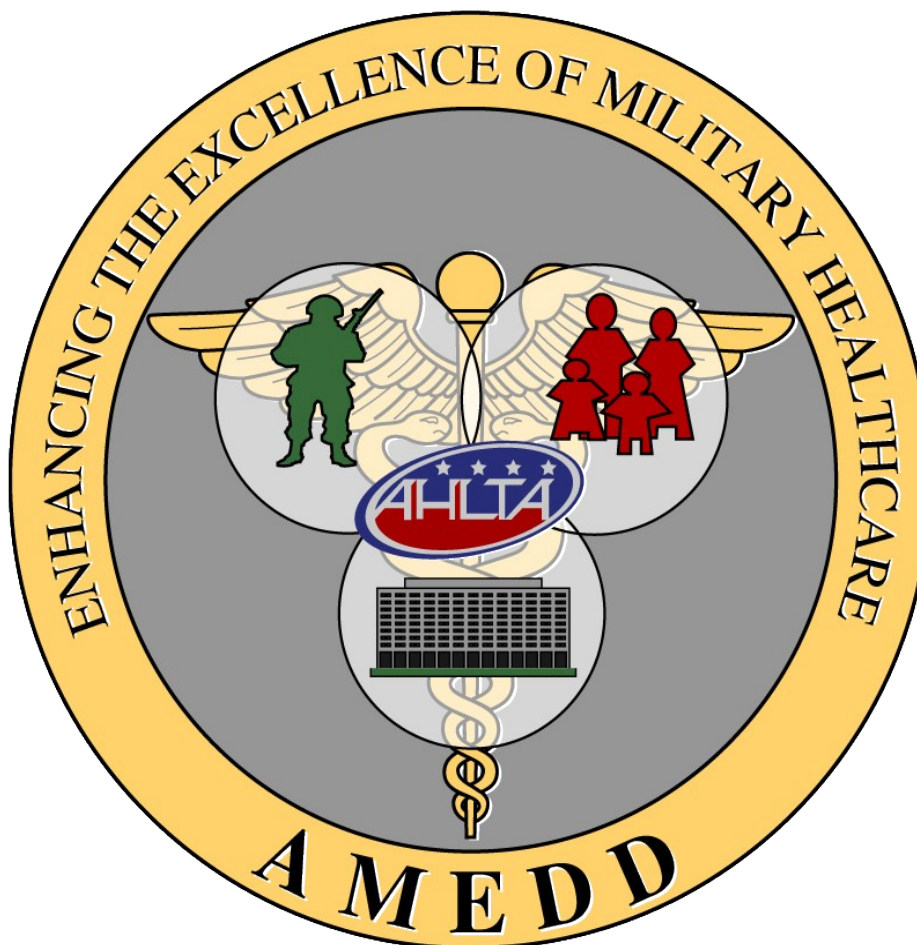
Seamless Soldier Care – Theater to
MEDCEN
Single Standard of Care – All
Patients/MTFs
Clinical Guidelines/Population Health
Business
Optimization
Post Deployment Surveillance
Evidence Based
Medicine/BioChem Early
Warning
Improved Access and
Efficiency
Longitudinal Care
Decreased Cost



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Questions





Back-Up Slides





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AHLTA Program Office Action Plan/Phases

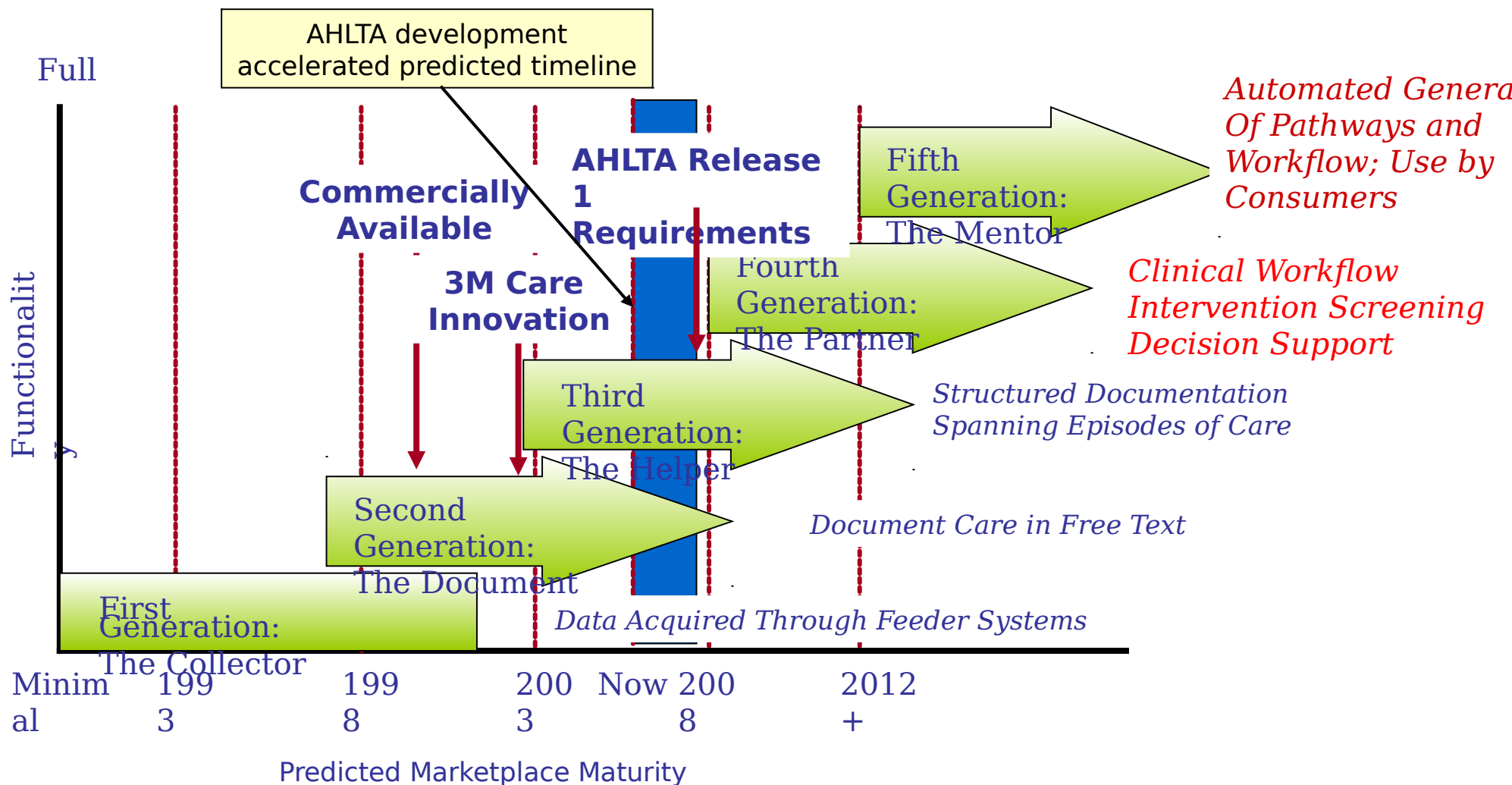
- Phase 1 – Deploy to all sites
 - Block 1 – Medical (Feb 04 to Sep 06)
 - Block 2 – Dental and SRTSII (Jan 07 to ??)
- Phase 2 (Jan 05 to Dec 06) Increase utilization by all sites and in all locations (Theater, BAS, SRPs, CBHCO)
 - Better training and tools
 - Preventive Health Reminders
 - Clinical Data Mart – Initial deployment
 - **Shared Solutions from the field**
- Phase 3 (Jan 06 to END) Improve Quality of Care
 - Deploy Clinical Decision Support / aCPG/Registry/Outcome tool
 - Enhanced CDM and eventual CDW
 - **Regulation and Policy Changes**
- Phase 4 (July 06 to END) Improve outcomes while decreasing costs
- Phase 5 (July 06 till ??) Prepare for inpatient success



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The CPR in US Industry: Gartner Group (1999)





Facts:

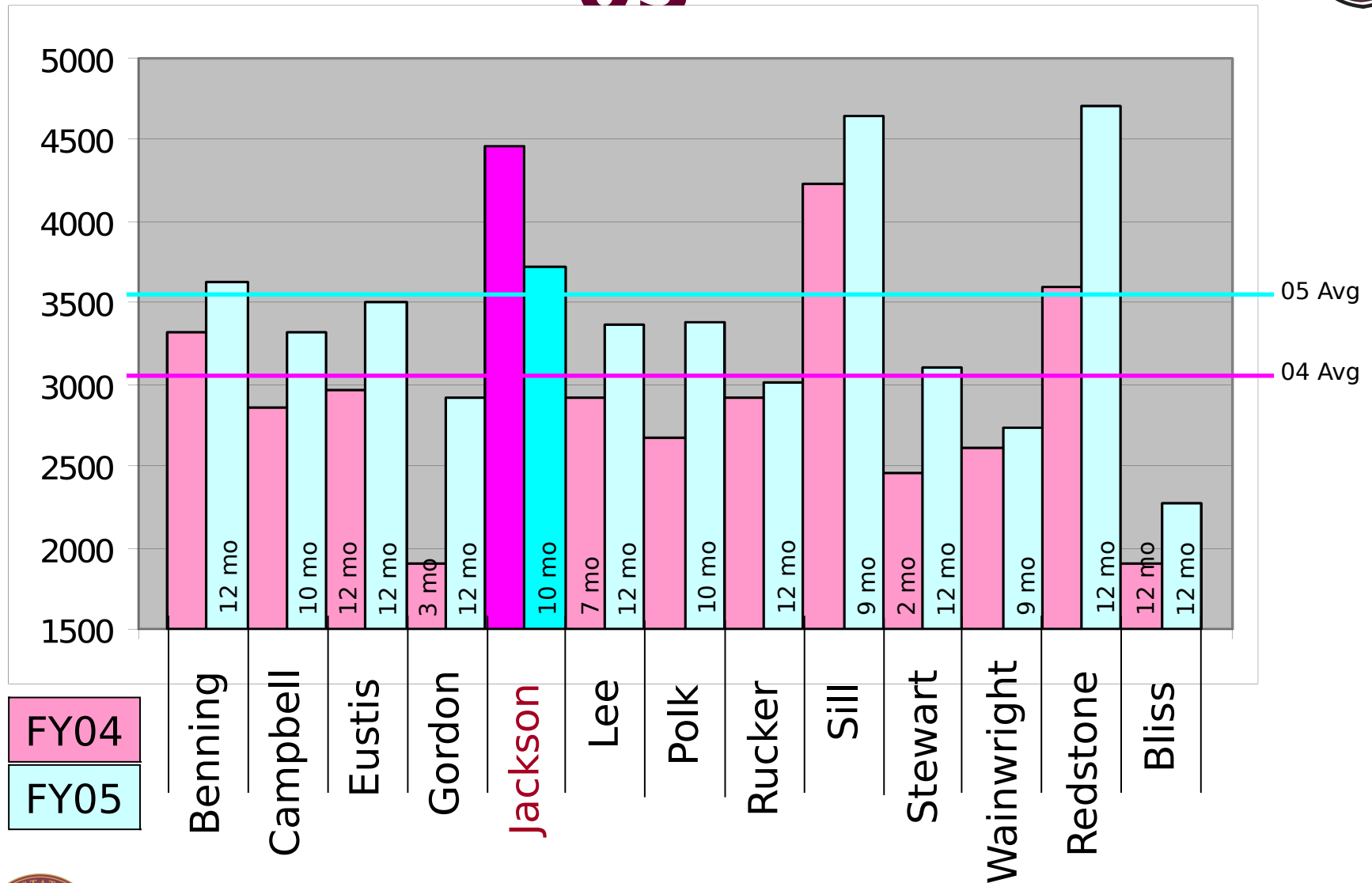
MTF Productivity and

Access

AHLTA Use Impact



Encounters/FTE from FY04-05

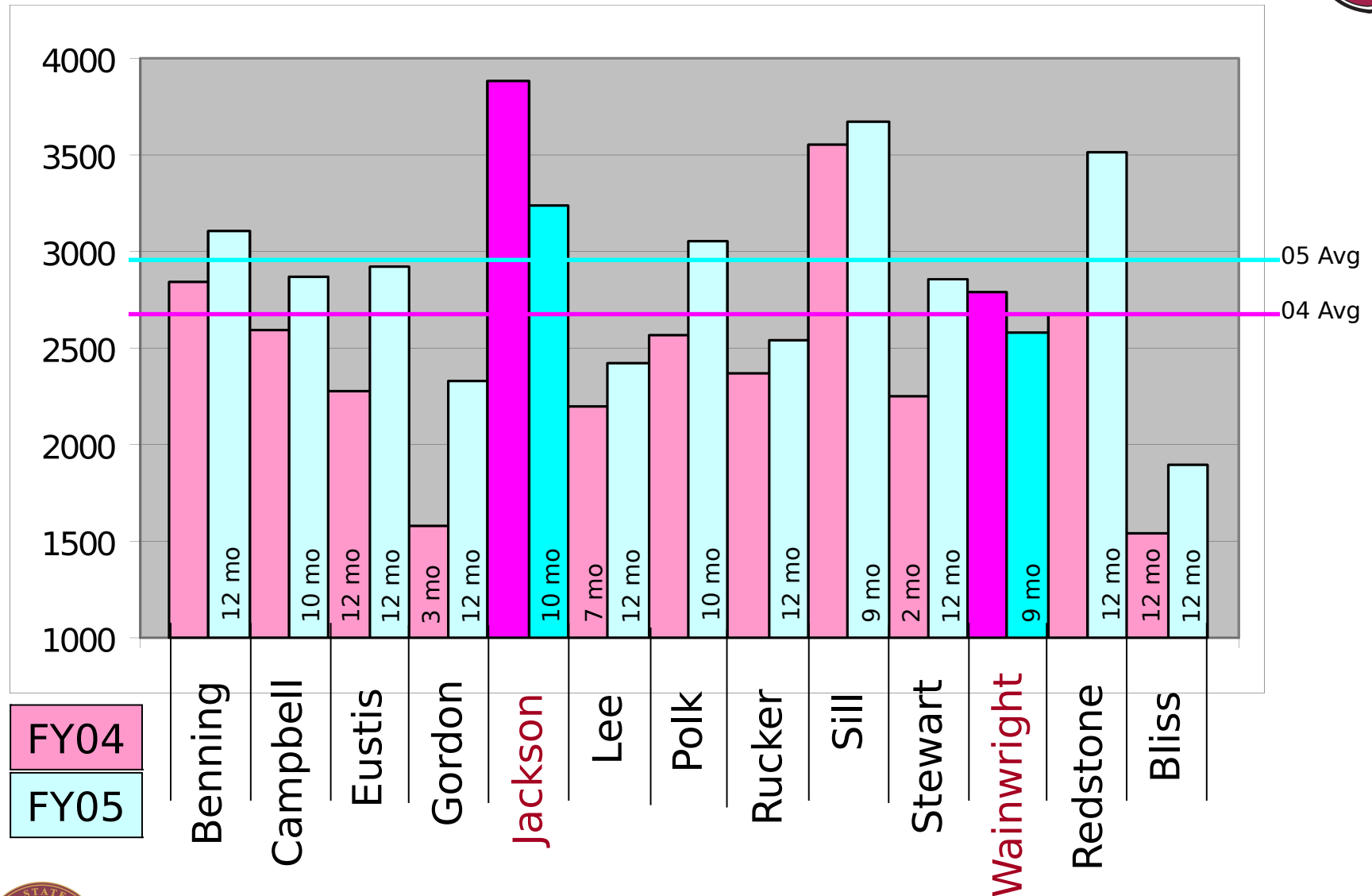


* Numbers in each column indicate the months using AHLTA during that FY



RVUs/FTE from FY04-05

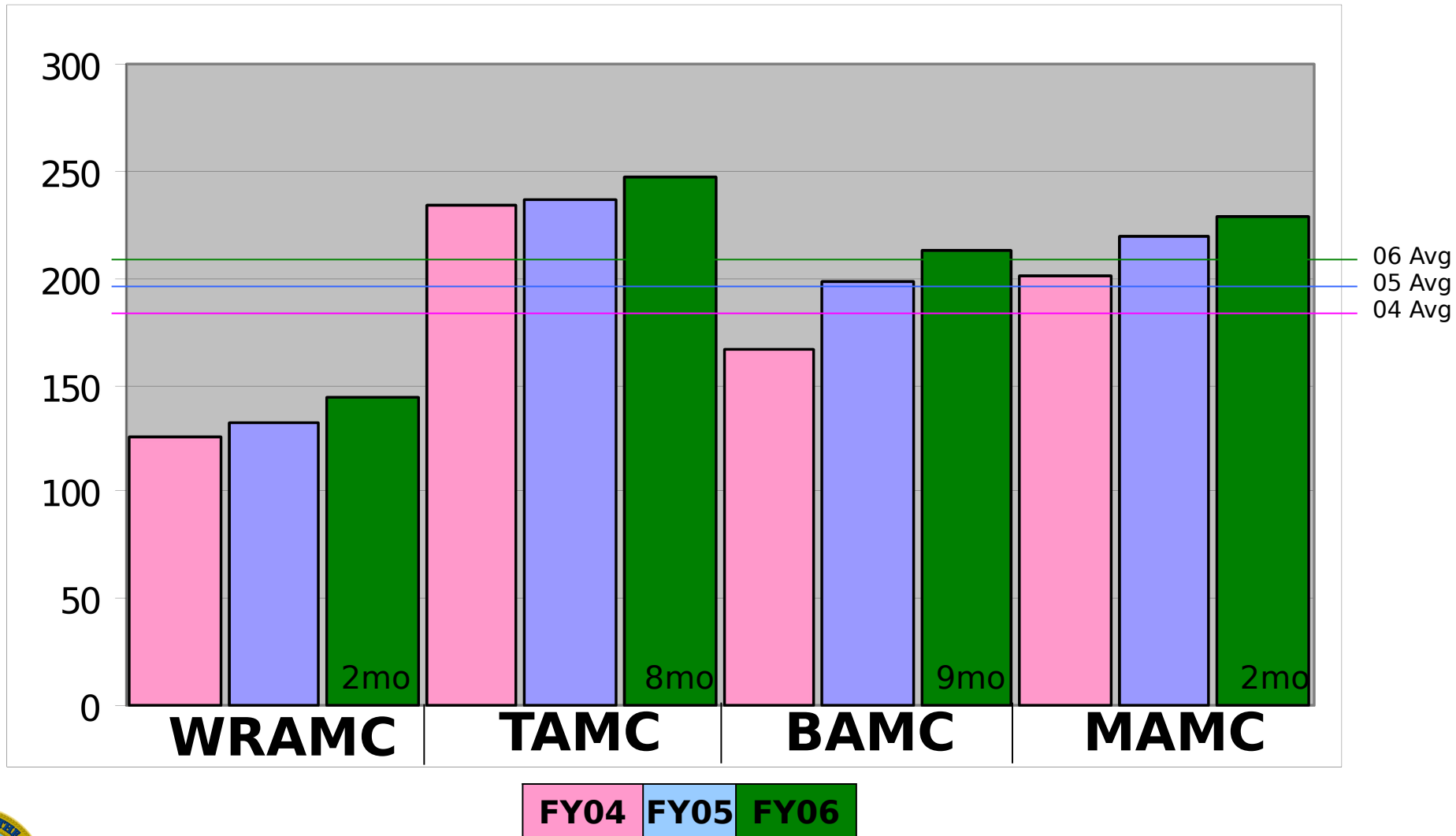
(From B MEPRS Clinics)



* Numbers in each column indicate the months using AHLTA during that FY



Encounters/FTE from FY04-06

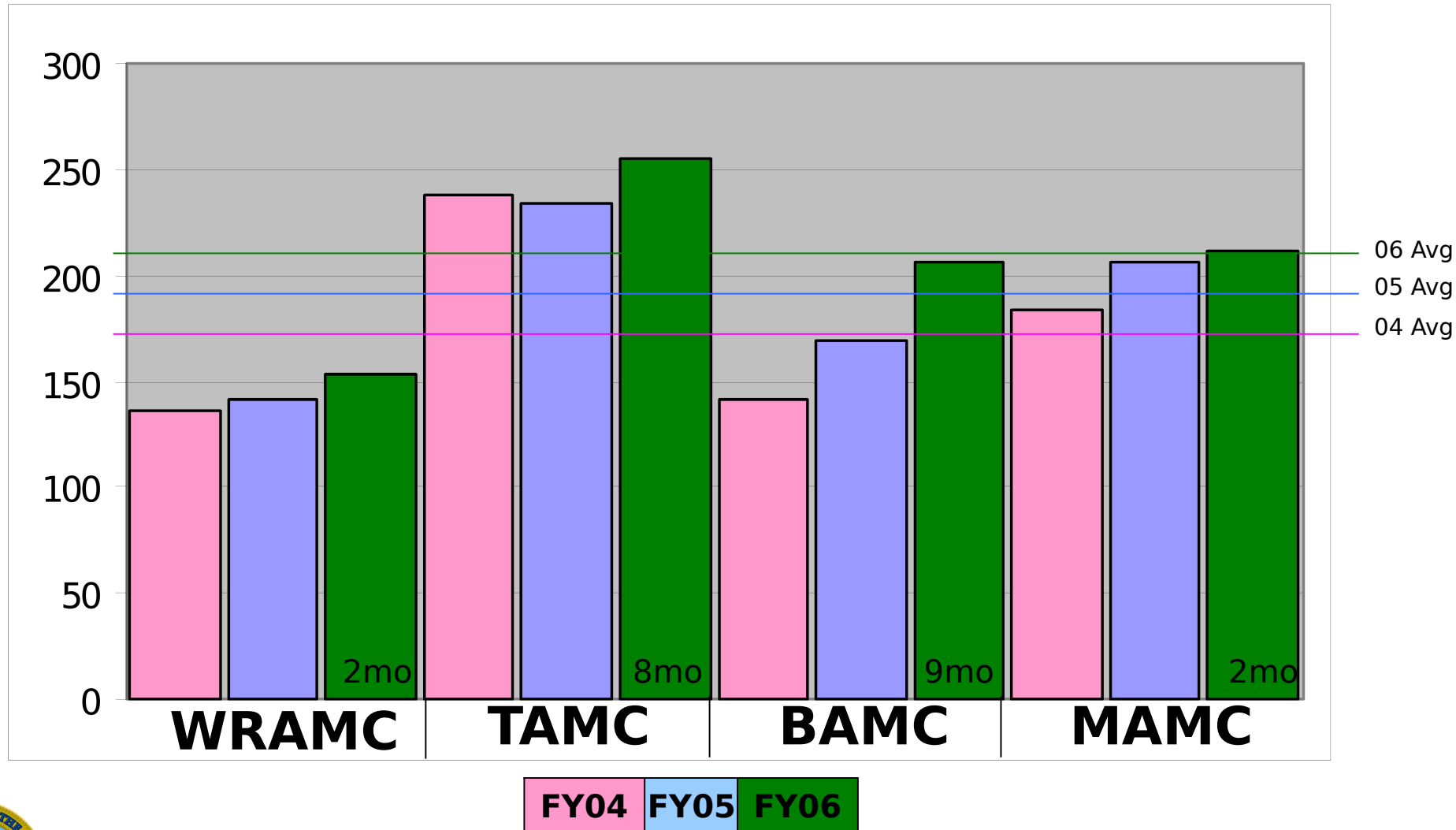


- FY06 data is through June 20 except for MAMC, whose data is through Oct 05
- Numbers represent the number of months measured AFTER training was complete



RVUs/FTE from FY04-06

(From B MEPRS Clinics)

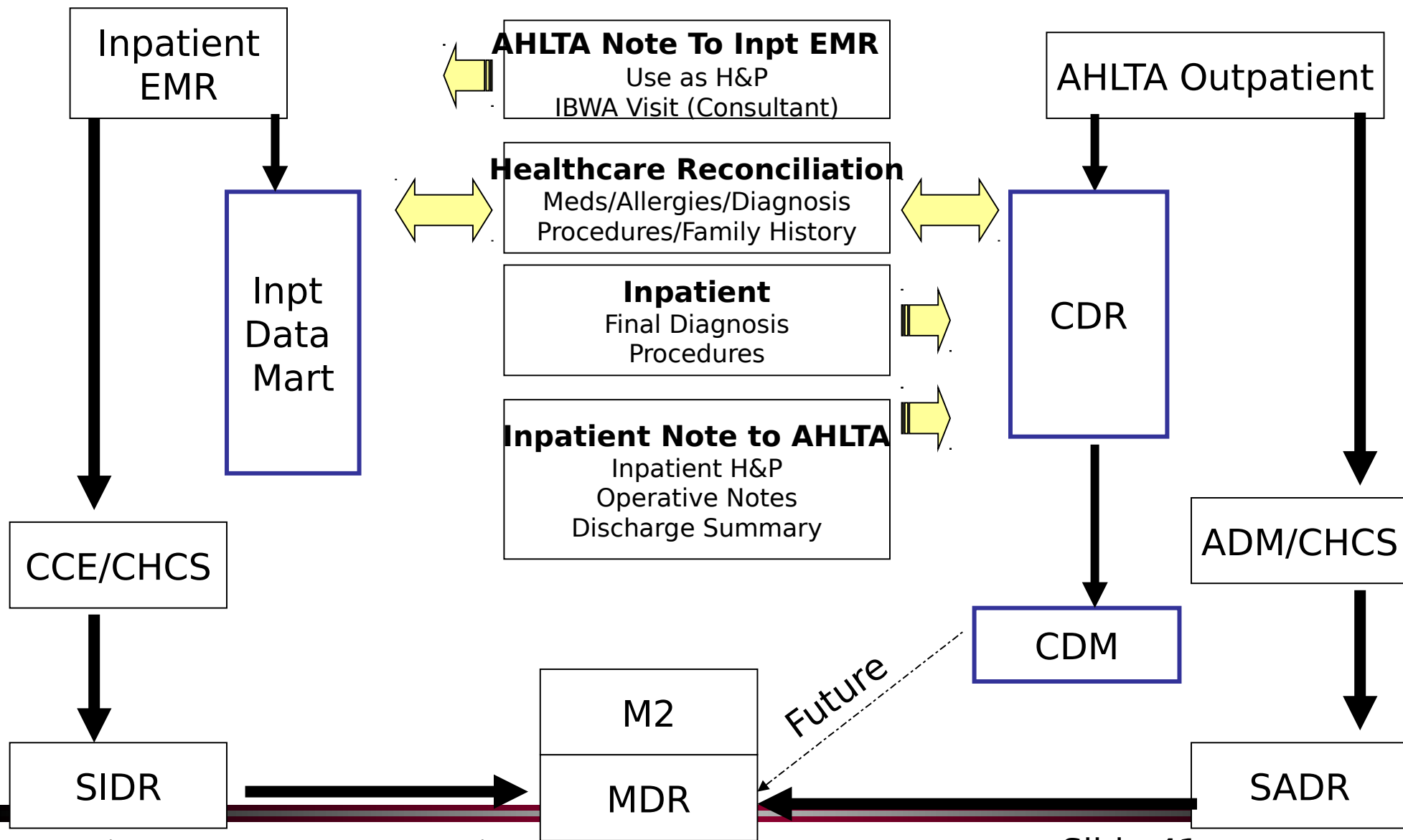


- FY06 data is through June 20 except for MAMC, whose data is through Oct 05
- Numbers represent the number of months measured AFTER training was complete





Conceptual Data Flow (Typical Inpatient)





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AMEDD and TMA Regulations/Policies: Updating and New

- Issue: Policy revision has not kept up with AHLTA use/deployment
- Discussion
 - Policies still refer to form numbers, not data elements/facts
 - Processes defined by policies – do not apply or create barriers to AHLTA use
 - Regulations due not consider fact that AHLTA is used for healthcare
- Recommendations:
 - New policies must consider AHLTA use and the time required to change AHLTA
 - Continue HP&S practice of rapidly reviewing key issues impacted by AHLTA to review and recommend interim guidance until formal policy updates occur



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MEDCIN New Feature Summary

New Feature - Must have

- **Custom Data Presentation Engine**- provides mechanisms to overcome some of the “Medcinspeak” and encounter note formatting and display issues

Features in Present AHLTA Version - Must Keep (We need to understand the risk for updates to these as AHLTA falls behind in versions)

- **Base Knowledge Engine**- the core Medcin server and associated vocabulary provided therein
- **Narrative Engine, Intelligent Prompting, Search Engine, ICD9CM mapping, CPT4 Mapping**
- **E&M Engine**
- **Multiple Code-Year Support**

New Features - Need

- **.Net Flow Sheet Tool**- Feature is the basis for a top 10 user request. This is part of the feature set that is unfunded in Phase 2 of the flow sheet ECP.
- **Follow-up Engine**- Provides documentation and flow sheet options in a follow-up context, rather than an initial diagnostic context. This too is the basis for requirements in the flow sheet ECP.
- **.Net Drawing Tool**- This is the “Drawing Tool Phase 2”. The tool was designed largely in coordination with MHS, principle AMEDD SMEs, and is based on the ECP requirements. The tool that was built is now part of the MEDCIN product list. MHS cost is now integration-only and would replace the basic “Phase 1” Drawing tool in Build 841.
- **.Net Encounter Entry Tool**- Updated version of current “S/O” tool. Provides improved methods of displaying the S/O template and the much-maligned “MEDCIN Tree”.

New Features - Desired

- **Alerts Engine**- new clinical decision support alerts (evaluates broad clinical data set for alerts and recommendations)
- **Coding Hints**- custom point-of-documentation coding help for several common coding problems/challenges

AHLTA - CHCS II-T (Theater) CONVERGENCE

AHLTA *(Features through Build 843)*



Direct Interface to CHCS

Screening Notifications
CAC Provider Login
Army IMR/Readiness
PHDRA
Tasking
SRTS
OB Summary
Dental
Wellness
Reminders Mapping
Readiness
Flowsheets
New Results
Alert Review
Patient Questionnaire
Patient Registry
Goal Summary
Plan of Care
Consult Log
Drug Cost
Drawing Tool
Pediatric Growth Chart
ADM P1/P2
aCPGs
ESF
Automated Coding
Admin Close Appt
HAMTD/TOL
Deployment Health Forms

Build 844

Access to sensitive data
Dictation/Transcription Equip Integration
ER Front End P1
Elect Pat Signature
Flowsheets
Integrated Immunizations
Multi-user Access
OB Documentation
Questionnaire enhancements
Review New Results Redesign
Security Matrix
Screening Module Redesign

Build 845

3Mv10
PKC Couplers
Upgrade
User specific Co-signer
Dropdown list
ID Card/CAC Scan
Order Management
PAP Tracking
Drawing Tool Phase 2
Reports/Order Management

Unassigned Provider

Couplers
S/O Note View
Appointments
Telephone Consults
Patient Search
Patient List
Screening
List Management
Template
Management
Demographics
Inpatient Care (Basic)
Disposition
Allergy
Lab
Meds OTC
Other Therapies

Sign Orders
Immunizations
Immunizations
Admin
Radiology
Problems
Current Encounters
Precious
Encounters
S/O Forms View
A/P
Diagnosis
Encounter Order sets
Procedure
Order Entry
Consults
Order Entry Lab
Order entry Rad
Patient Search

Issues

- C2T core capabilities have not been updated, lost "train as you fight" system
- Two baselines increase cost
- C2T features can benefit AHLTA

Recommendations

- Rapid Convergence
- AHLTA-T mode as form of local cache mode
- Move from CHCS NT to allow Theater ancillary data to CDR

CHCS II-T *(Unique Features)*

Triage Patient creation

DNBI

Data Manager

- EIC
- PIC
- PVF
- JMEWS

CAC (Patient Centric)

Data Migration

Inpatient Care

Documents

Inpatient List

Hosp Setup

Bed Assign

Inpatient Notes

